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July 7, 2006

VIA HAND DELIVERY

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon
Docket No. INS-06-900
Maine Bureau of Insurance
124 Northern Avenue
Gardiner, Maine 04333-0034

In Re: Review Of Aggregate Measurable Cost Savings Determined By Dirigo Health For The Second Assessment Year

FILING COVERSHEET

Dear Superintendent Iuppa:

Enclosed for filing please find the following:

SUBMITTED BY:	Christopher T. Roach
DATE:	July 7, 2006
DOCUMENT TITLE:	Anthem BCBS Reply Brief
DOCUMENT TYPE:	Brief
CONFIDENTIAL:	**NO**

Thank you for your assistance in this matter.

Very truly yours,

/s/ Christopher T. Roach

NON-CONFIDENTIAL

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE:	)	
	)	
REVIEW OF AGGREGATE	)	ANTHEM BCBS REPLY BRIEF
MEASURABLE COST SAVINGS	)	
DETERMINED BY DIRIGO HEALTH	)	
FOR THE SECOND ASSESSMENT	)	
YEAR	)	July 7, 2006
	)	
Docket No. INS-06-900	)	
	)	

NON-CONFIDENTIAL

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INTRODUCTION

Pursuant to the Superintendent's Notice of Pending Proceeding and Hearing dated April 26, 2006 and Order on Intervention and Procedures issued on June 15, 2006, Anthem Health Plans of Maine, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") submits this Reply Brief.

The Dirigo Health Agency Board ("DHA Board") hinges its opposition to Payor Intervenors' respective arguments on the proposition that the Superintendent's review of the DHA Board's decision is perfunctory because the Superintendent is required to apply the highly deferential standards a court applies in certain circumstances to agency findings. (*See* DHA Board Brief, pp. 2-3: citing standards applicable to review of administrative agency findings by a court.) As set out below, the DHA Board's suggestion of deference is wrong for two reasons: (1) the standard of review is set forth in the statute itself and does not include the highly deferential standards applicable to a reviewing court; but (2) even if those standards otherwise would be applicable, the procedural irregularities and failure to disclose that a voting DHA Board member is also a current member of the Board of Directors of Consumers for Affordable Healthcare ("CAHC"), and intervener in the proceeding, eliminates any credible argument that the Board's findings and determinations otherwise would be entitled to some deference.

It is difficult to respond on the merits to the DHA Board's brief because they begin with the proposition that everything they did, and everything they found, is entitled to nearly complete deference and, therefore, they do not respond to the vast majority of the specific arguments set out extensively in the Payor Intervenors' opening briefs. The Board relies instead on the assumption that the Superintendent will look no further than the citations they offer as supporting their positions on their determination of AMCS. To the contrary, the Legislature entrusted the Superintendent with the specific obligation of reviewing the work of the DHA Board for a

reason: the Superintendent and his Staff have the experience and established expertise to examine the complete record carefully and determine whether the Board's determinations are reasonably supported by the evidence in that complete record. That complete record includes all of the information set forth in Payor Intervenors' opening briefs, the vast majority of which the Board did not respond to, much less refute.

With a thorough (non-deferential) review of the record, it is clear that the Board's determination of $41.7 million of aggregate measurable cost savings ("AMCS") is not reasonably supported by the evidence in the record.

ARGUMENT

I. THE DHA BOARD DETERMINATION IS NOT ENTITLED TO DEFERENCE.

A. The Statute Establishes The Applicable Standard Of Review And Does Not Provide For The Nearly Complete Deference Suggested By The DHA Board.

Pursuant to 24-A M.R.S.A. § 6913(1)(C), the Superintendent is charged with determining whether the Board's AMCS "are reasonably supported by the evidence in the record." The DHA Board makes the leap from this applicable standard to Law Court cases establishing the standards by which courts should review factual findings and legal determinations. The Board's suggestion is understandable given their goal of having its determination affirmed, but at odds with the statutory construct and the well-established law in this State.

On their face, the caselaw quotations included in the DHA Board's Brief are accurate. As demonstrated below, however, the factual underpinnings that resulted in that deference in the cited cases are not present here.

Agencies are established to carry out particular regulatory responsibilities and, accordingly, often are staffed by individuals with specialized knowledge or experience particular to that regulatory responsibility. On matters within the agency's specialized area of expertise, courts generally give deference to the agency's determinations. This makes sense because the

reviewing court in most cases will lack that specialized expertise. *See, e.g., S.D. Warren v. Board of Env. Protection*, 2005 ME 27, 29, 868 A.2d 218, 219 (courts do not "'second-guess' an agency on issues within its area of expertise"); *York Ins. of Maine, Inc. v. Superintendent of Ins.*, 2004 ME 45, 30, n.3, 845 A.2d 1155, 1163 ("If the phrase is ambiguous, we should defer to the agency's interpretation of it, as long as that interpretation is reasonable, because the agency is charged with the implementation of the statute and the agency's expertise is appropriately utilized in determining its meaning.") (emphasis added).

If, on the other hand, the reviewing court does have expertise in the area or the statute at issue is unambiguous, the reviewing court accords no deference:

> Unless the meaning of a statute is clear or within our own expertise, we will defer to an agency's interpretation of a statute it administers when the agency's interpretation is both reasonable and within the agency's own expertise. [citations omitted] Therefore, when the statute is unclear and it is within the agency's expertise, we " 'limit our review to determining whether the agency's conclusions are unreasonable, unjust or unlawful in light of the record.

Botting v. Department of Behavioral and Developmental Services, 2003 ME 152, ¶9, 838 A.2d 1168, 1171 (emphasis added) (citations and internal quotations omitted).[1] Anthem BCBS believes the statutory provision that establishes the categories of cost savings that may be included in AMCS plainly and unambiguously permits in the calculation of AMCS only those

[1] The Law Court has articulated this underlying premise on numerous occasions:

> When reviewing an agency's interpretation of a statute that is both administered by the agency and within the agency's expertise, we apply a two-part inquiry. *Guilford Transp. Indus. v. Pub. Utils. Comm'n*, 2000 ME 31, ¶ 11, 746 A.2d 910, 913. First, we determine de novo whether the statute is ambiguous or unambiguous. *Id.* ¶ ¶ 11, 13, 746 A.2d at 913, 914. Ambiguous language is described as language that "is reasonably susceptible of different interpretations." *Id.* ¶ 14, 746 A.2d at 914 (quoting *Portland Valve, Inc. v. Rockwood Sys. Corp.*, 460 A.2d 1383, 1387 (Me.1983)). Then, we either review the Commission's construction of the ambiguous statute for reasonableness or plainly construe the unambiguous statute.

Competitive Energy Services LLC v. Public Utilities Com'n, 2003 ME 12, ¶15, 818 A.2d 1039, 1046.

cost savings that are the result of (1) the operation of the Dirigo Health Agency, and (2) increases in MaineCare due to expansions in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1)(A). The measures for CMAD, CON/CIF and PIP and Physician Fee initiatives are all most clearly outside of this plain language.

Though we believe it is clear, the Superintendent need not resolve that question at this stage because the present case also does not meet the second prong of the deference test: in this case, the parameters of the Dirigo Act are directly within the expertise of the reviewing agency (the Maine Bureau of Insurance). One need look no further than the Act's placement in Title 24-A, and indeed the Legislature's express directive that the Superintendent must review the Board's determinations, to discern that the Act certainly is not outside of the Superintendent of Insurance and his Staff's area of expertise.[2] Put differently, if, as the DHA Board necessarily must be asserting, the Act were outside of the Superintendent's area of expertise, why would he be directed to review the Board's determinations?

Also informative in the present case is the concept that courts defer on statutory interpretations when the particular agency "regularly administers" the statute. *See, e.g, Isis Development, LLC v. Town of Wells*, 2003 ME 149, ¶3, n.4, 836 A.2d 1285 ("Because of a state agency's professional and often technical expertise, we grant deference to its interpretation of a state statute or regulation it regularly administers, and uphold the agency's interpretation unless the statute or regulation compels a contrary result."). By contrast, the statute at issue involves

[2] The illogic of the Board's position is highlighted by their position on the interpretation of the Act. In a footnote, the Board "agrees that any decision on whether savings are reasonably supported by the evidence necessarily includes a decision whether the savings are reasonably included in AMCS." (DHA Board Brief, p.4, n.2.) The Board elsewhere suggests that the Superintendent must uphold the Board's interpretation "unless the statute plainly compels a contrary result." (DHA Board Brief, p.3.) This suggestion is contrary to the law and, other than to serve the purpose of preventing meaningful review, makes no sense.

fundamental interpretations of first impression that have not yet been determined by any reviewing court.

Thus, the underlying assumptions that could lead to deference under Maine law are not applicable here: (1) the reviewing entity is not a court with general legal knowledge, (2) the agency charged with reviewing the record, the Maine Bureau of Insurance, has specialized expertise in the very matters that are at issue in this case, and (3) this is a brand new statute raising interpretive issues of first impression. Moreover, even if one could argue that the Board's interpretation is entitled to any deference by a reviewing court, the Maine Bureau of Insurance "is charged with the implementation of the statute"; indeed, the Superintendent plays an integral role in the determination of AMCS because the Board, itself, is not authorized to determine a final AMCS number. That determination is left to the sound judgment of the Superintendent. As such, the Superintendent's interpretation would be entitled to deference by a reviewing court.

The Superintendent is the only disinterested agency head that will review the statute and the record evidence. It would turn the deference cases cited by the DHA Board on their heads if those authorities were used here to prevent meaningful and thorough review of the law and facts by the Superintendent. Even if the underlying caselaw were supportive of the Board's position (which it is not), the plain language of the Dirigo Act defies such a result.

The Act requires review by the Superintendent and sets forth the applicable legal standard. If the Legislature wanted to avoid meaningful review by the Superintendent, it certainly could have elected to provide for direct review of the Board's determination to the Superior Court by simply remaining silent on the issue. It did not. The Legislature explicitly required review by the Superintendent and the statutory language does not restrict the Superintendent's role at all: he must determine whether the record reasonably supports all of the

AMCS proffered by the DHA Board by reviewing the complete record (not just those select pieces of the record put forth by DHA or CAHC).

To transform this statutory language into the highly deferential standard suggested by the Board would defeat the purpose of the Superintendent's review and render it superfluous to the review performed by the courts in a Rule 80C appeal. *See, e.g*, DHA Board Brief, p.3 (suggesting the Board's burden is "quite low" and Intervenors' burden is "quite high.") Put differently, if the standard of review for the Superintendent is identical to that of the Superior Court, then why would the Legislature have required the Superintendent's review at all? And if that were indeed the way the statute worked, would that then mean that the Superintendent's decision is cast aside on any appeal to the Superior Court (as is the Superior Court's decision once appealed to the Law Court)? That interpretation would make no sense.

Instead, the legislation recognizes that the initial determination of AMCS is made following a presentation by the Dirigo Health Agency to its Board of Directors. That is, an agency whose mission is to provide as much funding as possible for its program makes a presentation to its Board, whose goal is the same. Following what all (most particularly, the Legislature) recognize will be a determination by a Board that is necessarily very interested in the outcome, the Superintendent is asked to review the record to determine – fairly and impartially – whether the evidence in the record supports the amount of AMCS requested by the DHA Board. *See* 24-A M.R.S.A. §6913(1)(C). Adopting the Board's suggestion of deference would result in the complete absence of meaningful review by a disinterested adjudicator, even though such a review is both directed by the Dirigo Act, *see* Section 6913(1)(C), and at the very heart of the Maine Administrative Procedures Act. *See, e.g, Gorham v. Town of Cape Elizabeth*, 625 A.2d 898, 902 (Me. 1993) ("[A]n applicant before an administrative board is entitled under

the due process clause of the United States and Maine Constitutions to a fair and unbiased hearing."); *see also Mutton Hill Estates, Inc. v. Town of Oakland*, 468 A.2d 989 (Me. 1983).

B. Even If The Law And Statutory Construct Otherwise Provided For The Deference Suggested By The DHA Board (Which They Do Not), The Board's Determinations Are Entitled To No Deference Because Of (1) The Extent And Degree Of The Procedural Irregularities That Marked The Proceedings, And (2) The Undisclosed Affiliations Of A Member Of The DHA Board To CAHC.

Deference to an agency's determinations is based on the foundational premises that the proceedings were conducted equitably, and by a fair and neutral body without the appearance of impropriety. Neither premise is supported, at all, by the record in this case.

1. The Procedural Irregularities Were Sufficiently Significant And Severe To Undermine The Board's Claim Of Entitlement To Deference.

In their opening briefs, Intervenors' recited the procedural irregularities that plagued this case from the initial notice of hearing and draft procedural order and all the way up through the hearings held more than a month after the statutory deadline for issuance of the AMCS determination. *See, e.g.*, Intervenors' Petition for Review of Agency Refusal to Act, Anthem BCBS Opening Brief, Attachment 3, ¶¶ 16-43. That petition chronicled the proceedings up to the point where Intervenors were forced to seek an order from the Court to require the Board to adhere to the statutory mandate to hold a hearing and issue a decision no later than April 1st. Thereafter:

- **The Superior Court (Marden, J.) determined that the Board had indeed failed or refused to comply with the very statute they now tell the Superintendent he must defer to them on**, *see Maine Ass'n of Health Plans v. Dirigo Health Agency*, 2006 Me. Super. LEXIS 73 (April 14, 2006);
- The court ordered the Board to issue its AMCS determination no later than May 12;
- The Hearing Officer permitted CAHC to offer an alternative methodology, notwithstanding that CAHC failed to comply with the deadline for identifying its alternative, *see* A.R. 516 (motion to strike); A.R. 1032 (order denying same);

- The DHA had to be ordered to respond to the Intervenors' FOAA requests, *see* A.R. 680;

- Medicare cost reports ("MCRs") form the basis for the vast majority ($72 million of $100 million) in AMCS suggested by DHA. DHA produced some of the 2005 medicare cost reports by May 5 (only one business day before the hearing was to commence);

- When it became clear to Intervenors that they had received only a fraction of the 2005 MCRs (7 out of 36 hospitals), when the hearing began on May 8, Intervenors objected. That objection was overruled, notwithstanding there was no answer to the question of the whereabouts of the missing 2005 MCRs, *see* A.R. 4974-4975, Tr. p.8, ln.4 – p.12, ln.16; A.R. 4994, Tr. p.85, ln.4 – p.87, ln.22.

- Intervenor counsel were forced to inquire of DHA's experts what MCRs they had received and when they had received them. In so doing, it became clear that, while Intervenors had only 7 of the 2005 MCRs, Mercer had 27 in their possession. (*See* A.R. 4994, Tr. 85, ln.4 – 87 ln.22);

Anthem BCBS will stop here. There are many other examples of the imbalance and partiality of the proceedings before the Board, but the record speaks for itself. We would invite the Superintendent to review the record in its entirety for himself to determine whether the Board's brief is accurate in suggesting that "the Board afforded the parties a fair and impartial hearing." We respectfully submit that the record is clear on this issue.

2. Independent Of The Procedural Irregularities, The Undisclosed Affiliation Of A DHA Board Member To CAHC Defeats The Board's Suggestion That Its Determinations Are Entitled To Deference.

In their Joint Filing of June 28, 2006, Payor Intervenors set forth their understanding of the facts surrounding Board member McCann's affiliation as a member of the Board of Directors of CAHC. Attached hereto as Attachment 1 is a copy of the June 28, 2006 filing. In a response served on June 30th, counsel for CAHC admitted that Mr. McCann is currently a member of the Board of Directors of CAHC.

It is undisputed that this information was not disclosed to counsel for Intervenors during the course of the hearing, nor was it publicly disclosed to anyone else in attendance at the hearing, including counsel to the DHA Board, counsel to DHA or Mr. Smith, the Hearing Officer. Indeed, the current state of the record reflects that the only individuals who were aware

of Mr. McCann's membership on the CAHC Board of Directors were Mr. McCann and counsel for CAHC.[3]

That the information should have been disclosed is obvious. Most tellingly, there has been no filing from the DHA Board or its counsel suggesting otherwise.

By arguing the same, the DHA Board acknowledges what it must: Intervenors were entitled to a fair and impartial hearing. (DHA Board Brief, p.4.) Even if the record would otherwise support that the process was entirely fair (which as reflected above, it does not), where one board member is potentially biased, the hearing is not fair, unbiased or meaningful:

> The hearing must be a fair, unbiased, meaningful hearing. . . . The hearing may be conducted in an orderly, courteous manner. All parties may get an opportunity to speak. The reasons for the denial may be articulated and supported by the record. Still the hearing is not fair, unbiased and meaningful.

Dunnells v. Town of Parsonsfield, 1997 Me. Super. LEXIS 37, *4; *see also Pelkey v. City of Presque Isle*, 577 A.2d 341, 343-344 (Me. 1990) (reversing planning board decision because, *inter alia*, one of the voting members had been a vocal opponent of petitioner's application prior to joining the board); *Burns v. Town of Harpswell*, 1991 Me. Super. LEXIS 137, *4 ("Generally, due process requires neutrality of the decision-makers"); *see also Friends of Oregon v. Wasco County Court*, 723 P.2d 1034, (Or. 1986) ("A decision on the merits by an adjudicator with a personal interest in the outcome is a violation of due process. That rule applies to administrative as well as judicial adjudications."), *citing Ward v. Village of Monroeville*, 409 U.S. 57 (1972); *Tumey v. Ohio*, 273 U.S. 510 (1927); and *Gibson v. Berryhill*, 411 U.S. 564 (1973).

The failure to disclose Mr. McCann's affiliation with CAHC undercuts entirely any argument for deference:

[3] CAHC's June 30th response is replete with assertions about Intervenor counsel's actual knowledge and motives. Intervenor counsel filed a brief response that same day to make clear when Mr. McCann's affiliation with CAHC became known.

> In holding the arbitration void, the [U.S. Supreme C]ourt [in *Commonwealth Corp. v. Casualty Co*., 393 U.S. 145 (1968)] emphasized the arbitrator's failure to disclose, which had prevented the petitioner, if it had so desired, from objecting to his serving [on the tribunal]. The lack of evidence of actual misconduct was irrelevant. "[A]ny tribunal permitted by law to try cases and controversies not only must be unbiased but also must avoid even the appearance of bias." *Commonwealth Corp*., 393 U.S. at 150.

Friends of Oregon, 723 P.2d at 1039 (voiding board action because of board member's failure to disclose prior affiliation with a party, the court "need not decide whether [the member] could have participated after disclosure if petitioners had objected."); *see also* 5 M.R.S.A. § 11007(4)(C) (3) & (4) (two explicit reasons for reversal or modification of an agency decision are if the decision was made upon unlawful procedure or affected by bias).

For all of these reasons, independently and collectively, the Board's legal and factual determinations are not entitled to deference.

II. THE BOARD HAS INCORRECTLY INTERPRETED THE DIRIGO ACT AND, AS A RESULT, SUBSTANTIALLY OVERSTATED THE AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR.

A. CMAD, CON/CIF And The Provider Fee Initiatives Are Not Within The Plain Language Of The Dirigo Act.

The DHA Board (1) argues for an unlimited scope of cost savings that it may count (*see* DHA Board Brief, pp. 6-7), but (2) suggests that the Superintendent need not examine this interpretation, or make his own, because the Board limited the categories of AMCS to CMAD, Uninsured, CON/CIF and Provider Fee Initiatives (*see id.*, p.7). This is a very slippery slope and one the Superintendent should not follow.

Let us be clear about the interpretation proffered by the DHA Board: the DHA Board suggests that the categories of cost savings that may be included in AMCS are essentially unlimited due to what it views as a missing comma. (*See* DHA Board Brief, pp. 6-7: "If the legislature had intended the meaning of Section 6913(1)(A) urged on the Superintendent by Payor Intervenors it would have placed a comma before and after the words 'as a result of the

operation of Dirigo Health.'"). "As a result of the operation of Dirigo Health," the Board argues, modifies only bad debt and charity care, and does not modify in any way the "aggregate measurable cost savings" text that precedes that modifier.

If the DHA Board's proffered interpretation of the language and law is accepted, then Anthem BCBS agrees that there are no limits to the categories of cost savings that may be included in AMCS. Stated another way, if the language following "aggregate measurable cost savings" merely establishes the floor for what may be included in AMCS and does not in any way modify "aggregate measurable cost savings", then the language may be read without those subsequent words and, therefore, as requiring only that the Board "determine annually not later than April 1st the aggregate measurable cost savings."

This interpretation, however, would beg the question what does "aggregate measurable cost savings" mean? It is not defined anywhere else in the Act, so under the Board's interpretation of the Act, the definition of AMCS is whatever the Board says it is and, they tell us, it may change over time. This is not a constitutional interpretation.

As evidenced by Justice Marden's Decision rejecting the Board's interpretation of the Act, the Board's track record in interpreting the Dirigo Act raises serious concerns,[4] and this

[4] Indeed, notwithstanding the plain language of the Administrative Procedures Act authorizing immediate review of an agency's failure or refusal to act, the DHA Board and CAHC took the position that Intervenors did not even have the right to petition the court to require the Board to hold the hearing and issue the decision required by the Dirigo Act. Justice Marden dispensed with that argument summarily:

> Instructions to this court are clear. *Eastern Maine Medical Center v. Maine Health Care Finance Commission*, 601 A.2d 99 (Me. 1992) discusses the issues raised dealing with the relationship between agency action and review by the courts. It makes reference to 5 M.R.S.A. § 11001 (1989) for the specific authority in the court to take appropriate action if a person is aggrieved by the failure or the refusal of an agency to act.

(*Maine Association of Health Plans v. DHA*, Civ. Docket No. AP-06-26, Decision and Order issued April 14, 2006, at p.2) (*Marden, J.*). It is accordingly no wonder that the DHA Board has interpreted the Act as imposing no limit whatsoever on the categories of cost savings that the Board may include in the calculation of AMCS.

unlimited interpretation of AMCS is equally without merit. In addition to being directly contrary to the legislative history articulating the legislators' understanding of the Act (*see, e.g.*, Chamber Hearing Exhibit 21—Legislative History, A.R. at 4731-87 (referencing that the Dirigo program would be funded via reductions in bad debt and charity care costs).), the Board's interpretation would be unconstitutional.[5] *See, e.g.*, Anthem BCBS Opening Brief, pp. 2-3.

Tacitly conceding that a limitless interpretation will raise constitutional concerns, the DHA Board attempts to provide some vague parameters around the language, suggesting indirectly that perhaps AMCS is "limited" to "savings from other initiatives that are identified or flow from the Dirigo legislation or other government initiatives." (DHA Board Brief, p.7.) The citation from the Board is not to the applicable section of Section 6913(1)(A) <u>because there is no such language in that section of the Act</u>. The Board does not explain how the plain language of a statute is discerned from language that is not even in the applicable section, much less plainly so.

In their attempt to maintain as broad an interpretation as possible and find the AMCS as high as possible, the Board refuses to limit the potential savings even to the Dirigo legislation at large (itself an overly broad interpretation that is inconsistent with the plain language), instead suggesting that savings from "other government initiatives" could also be included. Because this inferred "limitation" provides no greater degree of specificity on the categories to be included in AMCS, the interpretation proffered by the Board would remain unconstitutionally vague.

It is well-established that statutes must be interpreted in a constitutional manner, if the language so permits. *See, e.g., State v. Nastvogel*, 2002 ME 97, ¶9, 798 A.2d 1114, 1118 (In response to argument that statute was unconstitutionally vague, Law Court recited well-

[5] Contrary to the DHA Board's suggestion (DHA Board Brief, p.7), Payor Intervenors have not argued that the Act is unconstitutionally vague on its face. Rather, Payor Intervenors have made clear that the plain language of the Act provides parameters for AMCS, but the DHA Board's interpretation, which provides none, would render the Act unconstitutionally vague.

established rule that "[s]tatutes are presumed to be constitutional, and we are bound to avoid an unconstitutional interpretation of a statute if a reasonable interpretation of the statute would satisfy constitutional requirements.") (citations and internal quotations omitted).

Here, the language of the statute clearly permits a constitutional interpretation: aggregate measurable cost savings include bad debt and charity care reductions and must be "as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A). This interpretation is consistent with the legislative intent reflected in the legislative history and is sound legally from the plain language of the statute and, alternatively, from the principles of *ejusdem generis*, and should be adopted by the Superintendent.

Because only the Uninsured Initiatives are within the plain language of the Act, the Superintendent should reject the Board's inclusion of cost savings from the CMAD, CON/CIF and the Provider Fee Initiatives.

B. Even If Measures Beyond Uninsured Initiatives Are Within The Plain Language Of 24-A M.R.S.A. § 6913(1)(A), Which They Are Not, The Superintendent Should Reject The Board's Contradictory Positions That Result In Their Inclusion Of CMAD Savings For Both Year 1 And Year 2.

In Intervenors' opening briefs, we explained that the Board's justification for including CMAD in the year 1 savings assessment was the voluntary target for hospital cost growth set forth in the Dirigo legislation and the corresponding absence of such a target in the legislation for the second assessment year precludes its use in calculating AMCS in year two. In spite of the absence of any statutory authorization, the DHA Board determined that the voluntary target announced by the Maine Hospital Association is sufficient to relate CMAD savings for year 2 to Dirigo. Counsel to the DHA Board told the Board that they could not have it both ways, (*see, e.g.*, A.R. 3062), and he was correct.

It is undisputed that there is no voluntary target in the legislation for year 2, and the only testimony on this point from the head of the MHA was unequivocal that the MHA's voluntary cost growth target was unrelated, in any way, to Dirigo. (*See, e.g.*, A.R. 5148, Tr. 75, lns. 18-24: "We can keep going all day on this. The answer is this: In the second year, in the second year, the Maine Hospital Association, not Dirigo, not the State of Maine, nobody else, established a voluntary cap for hospital expenses. That's the answer. Not Dirigo related, 100 percent Maine Hospital Association related.").

To reject this unequivocal testimony by the head of the entity that announced the voluntary cap and find that the MHA's voluntary cost growth cap was as a result of Dirigo, the Board would have to have determined that Mr. Michaud provided false testimony. There is no support in the record for that assertion. Accordingly, the record does not reasonably support the Board's contention that the MHA's voluntary cost growth target is related to Dirigo, much less to the operation of Dirigo Health, as the statute requires.

C. The Use Of Inconsistent Time Periods To Measure Savings Is Not Authorized By The Act, Is Inconsistent With The Superintendent's Directive Following The First Year Assessment, And Results In Overstatement Of Cost Savings.

Intevenors explained the different measuring periods for the second assessment year, but the DHA Board's own recitation of the different periods is a better representation of the machinations that the DHA performed:

> The record in this matter shows that for the second assessment year the Board used the following measuring years: CMAD – July 1, 2004 to June 30, 2005; BD/CC (Uninsured and Underinsured) – January 1, 2006 to December 31, 2006; BD/CC (MaineCare enrollment) – July 1, 2005 to December 31, 2006; BD/CC (Woodwork Effect) – July 1, 2005 to December 31, 2006; CON/CIF – January 1, 2006 to December 31, 2006; and, Provider Fees – January 1, 2006 to December 31, 2006. These measuring years follow sequentially the measuring years used for the first assessment year except for BD/CC (MaineCare Enrollment) and (Woodwork Effect), which reach back to July 1, 2005 to recoup savings not assesses in the first assessment year.

(DHA Board Brief, p.8.)

There is no statutory support for using these different measuring periods.

Anthem BCBS will leave it to the Superintendent to determine whether these multiple and convoluted measuring periods are what he had in mind when directing that AMCS should be measured over a consistent time period.

The private payers will pay for the alleged savings in the second assessment year starting in 2007 and the cost savings should have been measured only for the second assessment year: July 1, 2004 to June 30, 2005. Applying interest does not remedy the problem; indeed, it exacerbates the flaw because interest is used to enhance savings amounts from different periods. Put differently, if the four measures collectively would yield $100 in savings if all were measured over SFY 2005, but $200 using the Board's approach of measuring different time periods, it hardly "fixes" this problem to apply interest to the $200.

D. The Board's Justification For Failing To Limit Cost Savings To Those That Are Attributable To The Private Payors Is Not Reasonably Supported By The Record.

It is undisputed that private payors account for less than 35% of the utilization and associated revenues of Maine hospitals and that the DHA Board methodology makes no adjustment to reflect this reality. (*See, e.g.*, Michaud, A.R. at 5147, Tr. 70, ln. 23 – Tr. 71, ln. 7; *see also* Hearing Testimony of Thomas Drottar, A.R. at 5174, Tr. 180, lns. 18-25; Schramm, A.R. at 5125-26, Tr. 136, ln. 12 – Tr. 137, ln. 5.) In the face of these facts, the DHA Board asserts that "all cost savings accrue to the market", so they are assuming it is reasonable to charge an SOP that imbeds cost savings associated with discharges, at least 65% of which are, without dispute, unrelated to the private payors who pay the SOP.

As the record demonstrates, this is unreasonable:

> Q. Could that benefit to the payers [i.e., 100% of the calculated AMCS] be the full amount of the bad debt and charity care cost savings that you had calculated if

you did not adjust for the fact that 50 percent of hospital revenues come from other than private payers?

A. [by Mr. Russell] It depends on the circumstances of the negotiation between the payers and the providers.

Q. It would help you disproportionately, right? There would have to be the full 100 percent of the savings calculation that you have calculated would have to go to the 50 percent private payers under your analysis in order for your calculation to be reasonable and not need adjustment; isn't that right?

A. That's correct.

(Russell, A.R. 5001, Tr. 113, lns. 5-18.)

III. INDEPENDENT OF THE BOARD'S INAPPROPRIATELY BROAD READING OF THE ACT AND USE OF INCONSISTENT TIME PERIODS, THE BOARD'S DETERMINATIONS OF THE VARIOUS COST MEASURES SUBSTANTIALLY OVERSTATED AMCS.

A. CMAD Is Not Reasonably Supported By The Record And Should Be Rejected.

The reasons that the DHA Board-adopted methodology for CMAD overstates savings are set forth in Intervenors' opening briefs. The DHA Board responds to a few of the Intervenors' comments, each of which is discussed *seriatim*.

The DHA Board first argues that its adopted CMAD methodology "by aggregating all hospitals, smoothed out the variations in CMAD that occur on an individual bases." (DHA Board Brief, p.10.) The record evidence establishes that the aggregation methodology, while less susceptible to individual hospital fluctuations, is anything but "smooth." (*See* Anthem BCBS, Exhibit 8, Attachment 1 to Anthem BCBS Opening Brief: reflecting aggregate cost growth variation of 4.7%, 10.12%, and 3.32% from SFY 2000-2003.). As this data amply demonstrates, even in the aggregate, hospital cost growth fluctuates naturally year-to-year. The DHA Board methodology captures these natural fluctuations and deems them "savings as a result of Dirigo" without any analysis of whether this is truly the case, or even whether hospitals actually achieved the calculated cost savings.

As the Superintendent is aware, Anthem BCBS disagrees with the DHA Board's affirmative de-linking of its methodology from a more realistic calculation of the amounts of "savings" that have actually inured to the benefit of the private payers who will pay the SOP. The DHA Board adopted methodology, however, goes even one step further. In addition to avoiding a determination of how much savings have actually accrued to private payers, the DHA Board would have the Superintendent ignore what amount of cost growth reduction, if any, that hospitals have actually experienced. Put differently, the Mercer methodology does not measure how much savings actually inure to the private payers on the back end; but the methodology also fails to measure how much cost savings are actually experienced by the hospitals on the front end. Instead, the methodology theorizes what might be available and goes no further.

Inasmuch as the methodology measures neither of these actual cost savings, the DHA Board methodology is affirmatively entrenched in speculation.

The Board next suggests, as did DHA's consultant, that by including "negative savings" that are not attributable to Dirigo, essentially it all comes out in the wash. (DHA Board Brief, p.10.) It is not reasonable for the DHA Board to have accepted this proposition without performing any level of verification with the hospitals that are supposed to have experienced the reduction in cost growth. Moreover, the proof that this suggestion is false is reflected in the actual data itself: actual cost growth during the measuring year accelerated far beyond historical averages, or the median selected by the DHA Board, yet the Board accepted $14.5 million in "cost savings" under the auspices that hospitals actually had reduced cost growth in SFY 2005.[6]

[6] The Board suggests that the flaw in this analysis is that it is appropriate to project from 2003 and ignore actual hospital costs for 2004. (DHA Board Brief, p.10.) As explained in Anthem BCBS's opening brief, the DHA's proffered methodology would have produced cost savings in a year in which actual costs grew by 10.26%. The suggestion that this is a reasonable methodology is belied by the historical data upon which it is based.

If the Board's methodology were accepted, private payer rate increases would reflect both (1) the acceleration in provider cost growth reflected in the data, and (2) $41.7 million that is supposed to reflect cost savings that they have experienced. This simply does not add up.

For all of the reasons set forth above, and in Payor Intervenors' opening briefs, the record does not reasonably support including $14.5 million in CMAD cost savings and should be rejected.

B. The DHA Board Fails To Respond To The Majority Of The Flaws In The Methodology And Calculation Intervenors Set Forth On The Uninsured Initiatives And, Instead, Relies On The Presumption That The Superintendent Will Look No Further Than Its Own Record Cites.

In pages 12-14 of its brief, the DHA Board sets forth its views of the Uninsured Initiatives. In so doing, the Board failed to respond to the majority of the flaws the Intervenors pointed out in their respective briefs, but instead, simply repeats the analysis proffered by DHA. The DHA Board does, however, respond briefly to (1) the failure to account for the crowd out effect, and (2) counting DirigoChoice members already enrolled as "uninsured" for purposes of calculating savings. (*See* DHA Brief, p.13.)

With respect to crowd out, without citation, the DHA Board states "[i]t is highly unlikely that persons who enrolled in MaineCare were previously insured." (*Id*.) Contrary to this assertion, the only evidence in the record – from DHA's own witness – is that the ranks of private insureds are declining and the ranks of the uninsured are relatively stable. (*See, e.g*, Russell, A.R. 4996, Tr. 95, ln3-96, ln.24.) Moreover, the documents produced by Mercer demonstrate that they performed analysis of the crowd out effect, but that analysis showed negative savings and it was ignored. (*See, e.g.*, A.R. 3264, 3442, 4990, 5014.)

The DHA Board goes on to suggest that it is appropriate to re-count DirigoChoice members who enrolled prior to the second measuring year because "these persons would be uninsured for the second assessment in the absence of DirigoChoice." (DHA Board Brief, p.13.)

Again, there is no record support for this proposition. The testimony from DHA's witness Mr. Russell, set forth in Anthem BCBS's opening brief, is to the contrary. (*See* Russell, A.R. 4997, Tr. 96, ln. 23 – 97, ln. 24: acknowledging that people go on and off the insured ranks year over year, irrespective of Dirigo.) The DHA Board methodology assumes that those who enroll in DirigoChoice would have remained uninsured until death, notwithstanding that the testimony from DHA's only witness on this point is to the contrary. As such, this assumption is not reasonably supported by the record.

The Board fails to rebut any of the other arguments raised by Intervenors in their opening briefs. The cost savings associated with the Uninsured Initiatives should be reduced to reflect these significant flaws.

C. The CON/CIF Cost Savings Are Duplicative, Not Reasonably Supported By The Evidence In The Record, And Should Be Rejected.

Intervenors articulated their significant concerns with the CON/CIF methodology in their opening briefs: (1) it is undisputed that the methodology is duplicative of savings calculated in the CMAD measure; (2) it includes as present-day "savings" reductions in projects that were not to have been started until some point in the future; (3) it assumes all projects would have remained exactly as set forth in the original application, notwithstanding all of the undisputed testimony that hospitals regularly modify project applications for a wide variety of reasons, irrespective of Dirigo; (4) the thresholds upon which the methodology is based pre-dated the Dirigo legislation; (5) there was no follow-up with any of the hospitals for which "savings" were calculated to determine the reason(s) the projects were modified or withdrawn, again, notwithstanding the undisputed testimony that this occurs regularly; and (6) the methodology was developed without anyone with expertise in the CON/CIF area.

In response, the Board simply reiterates DHA's methodology and suggests it is reasonable. (DHA Board Brief, pp. 14-15.) With respect to double-counting, the Board suggests

"it will be necessary to account for the savings back in the measuring year in which construction begins and costs are incurred." (*Id.*, p. 15.) There is no explanation as to why the Superintendent should accept these speculative, future, potential cost reductions that we know (if real) will show up in a future CMAD calculation. This methodology is wholly unreasonable and should be rejected.

D. The $15.2 Million Of Cost Savings Calculated By The DHA Board Methodology Is Not Reasonably Supported By The Record.

The DHA Board responds briefly to Intervenors' arguments concerning the PIP payments and physician fee increase by suggesting that the calculated amounts are additional dollars "in the health care system . . . because the infusion of additional money reduces the need for cost shifting to private payors." (DHA Brief, p.15.) Putting to one side all other arguments on these initiatives and focusing on even the one point to which the Board responds reveals the fallacy of including $15 million for these initiatives.

Mercer begins the analysis based on the proposition that increases in PIP payments were unexpected by hospitals; that is, that the State would continue to under-pay its Medicaid obligations at historical levels. Therefore, the methodology deems the full increase in PIP to be "additional money." Given that the State is in arrears, it is incorrect to characterize a reduction in the arrears as "additional money" because that assumes that, in the absence of the operation of Dirigo Health (or even as a result of Dirigo), the State would continue under-paying the amounts it owes to hospitals. There is no support in the record for that proposition.[7]

[7] In addition, hospitals that have been chronically underpaid by Medicaid are likely to use the additional PIP funding to replenish their balance sheets and thereby to protect themselves against future financial problems including some that might be caused by Medicaid in the coming years. Moreover, expansions in the number of persons covered by Medicaid, and in the level of utilization per Medicaid enrollee, create additional PIP needs that tend to offset the beneficial financial effects of the increase in PIP funding. Therefore, the suggestion that an increase in PIP automatically translates to reductions in costs for private (*footnote continued on next page*)

The Mercer methodology then calculates PIP savings using 100% of the difference in PIP between (1) SFY 2005 and SFY 2006, and (2) SFY 2005 and SFY 2007, notwithstanding that there is no evidence in the record concerning the purported increase in PIP for SFY 2007. *See* Mercer Year Two Report, Appendix H, A.R. 1436. Put differently, the methodology counts the increase in PIP for the first measured year (2005 to 2006), and then re-counts that difference by calculating the second component as the difference in PIP between 2005 and 2007. This leads to a total (overstated) PIP increase of $48,100,039. (*Id*.)

Although the theory underlying including the PIP increases in AMCS is that there is a reduction in hospital debt carrying costs as a result of these increased payments, Mercer thereafter treats the increased PIP payments as increases in revenue that would be invested, rather than allowing the hospital to avoid the carrying charges associated with borrowing money to fund the State's underpayments. The resulting "savings" based on Mercer's calculation of the time value of money is $7,020,260, (*id.*), or 14.6% (*e.g.*, $7,020,260 ÷$48,100,039 = 14.6%). Thus, the Mercer methodology (1) assumes that there is an impact on all hospital cost shifting as a result of the PIP increases, (2) counts the PIP increase from 2005 through 2006 twice, (3) assumes that 14.6% of that total increase in PIP is the measure of the impact on cost shifting. The record does not support this methodology or calculation.

The only hospital specific testimony introduced on this point at the hearing was by Mr. Michaud. In contrast to the Mercer proposed methodology, Mr. Michaud testified that for some hospitals, there will be no impact on cost shifting from any increase in PIP payments, and for those for which there would be an impact, only 4% of any PIP increase could actually result in a

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(*continued footnote*)
payers, who must negotiate with hospitals to determine mutually acceptable payment rates, is an unreasonable characterization of the financial exchanges that take place in the hospital market.

reduction in cost shifting. (Michaud Prefiled Testimony, p.5, A.R. 4308.) This makes sense because, from a revenue perspective, hospitals book the entire MaineCare obligation as revenue during the fiscal year, so the PIP increases only affect cash flow, and cannot provide an opportunity to reduce charges or cost shifting unless the increased cash flow provides an opportunity to pay off an interest bearing expense

Even assuming the PIP increase impacts all hospitals (which the record evidence does not support), and that it is appropriate to measure calendar year 2006 without any record evidence to support the fact that there will be a PIP increase in SFY 2007(which, again, is not supported by the record), the PIP savings should be limited to 4% of the PIP increase for calendar 2006:

Half of SFY 06 increase (½ of (SFY 06 – SFY 05)):	$18,976,982
Half of SFY 07 increase (½ of (SFY 07 – SFY 06)):	$10,146,075
Total increase in PIP to be paid over calendar year 2006:	$29,123,057
Total potential reduction in carrying costs if full PIP increase for calendar year 2006 paid on January 1, 2006 ($29,123,057 * .04):	**$1,164,922**

It would be inappropriate to apply the 4% reduction in carrying costs to the full $29,123,057, however, because there is no evidence in the record to support that 100% of the PIP increase were received by the applicable hospitals on January 1, 2006. To the contrary, the record reflects that PIP payments are made weekly. (Michaud Prefiled, p.4, A.R. 4308.) Thus, the total PIP increase of $29,123,057 equates to weekly increases in PIP of $560,058.79 ($29,123,057 ÷52 = $560,058.79). Again, assuming that 100% of all hospitals had a carrying cost associated with 100% of the now increased PIP, it would therefore be appropriate to apply the 4% reduction in carrying costs only to the first $560,058.79 increased payment to reflect the full calendar year 2006 reduction in carrying costs for that amount (*i.e.*, $560,058.79*.04 = $22,402.35 reduction in carrying costs associated with receipt of the first increased payment).

Each successive increased payment, however, would be received one week later than the immediately preceding payment and, accordingly, the time value of the reduction in the

associated carrying cost savings would be reduced by one week's time. For example, the reduction in carrying costs associated with the second weekly increase would reduce carrying costs by the increased PIP for that week ($560,058.79) multiplied by the carrying cost factor remaining for calendar year 2006 (.04 * 51/52) to reflect the receipt of that increased payment one week later than the first: $560,058.79 * (.04*51/52) = $21,971.54. When applying this formula to the full 52 weekly PIP increases, the total amount of potential cost savings available for a reduction in cost shifting – the standard articulated by DHA – would be **$593,662.32**.

For all of these reasons, the amount of AMCS attributable to PIP should be eliminated, or alternatively, reduced to a maximum of $593,662.32.

Anthem BCBS will not belabor the point on the physician fee increase because the Superintendent is well aware of the facts and can determine whether it is reasonable to assume that 100% of the physician fee increase is available for a reduction in physician charges and should be returned to carriers for ultimate return to DHA. It is, however, ironic that the State could tout a physician fee increase that will result in (1) $0 net increase to physicians; (2) return of 100% of the fee increase by those with private insurance; or (3) some combination of both. This measure is unreasonable and unsupported by the record.

IV. CAHC'S ARGUMENTS ARE CENTERED ON EVIDENCE THE SUPERINTENDENT HAS DEEMED INADMISSIBLE AND, ACCORDINGLY, SHOULD BE REJECTED.

CAHC argues that it was not reasonable for the Board to reject DHA's proposed historical average and, instead, adopt the 4.7% median growth rate reflected in Chamber Exhibit 21. CAHC's argument is premised on (1) a statement by one of the Board members during the deliberations, and (2) evidence the Superintendent has deemed inadmissible in this proceeding. Because neither premise is "evidence in the record," the Superintendent should reject CAHC's

position. *See* Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Second Assessment Year, INS-06-900, Order on Motions, p.3 (June 26, 2006).

CONCLUSION

For the reasons set forth above and in the Opening and Reply Briefs of Payor Intervenors, the methodologies recommended by the Dirigo Board are fundamentally flawed and do not yield an accurate calculation of AMCS that comports with the Dirigo Act. As the Dirigo Act directs, the AMCS calculation should include those cost savings that are the result of the operation of Dirigo Health and expansions in MaineCare. The methodology and calculations of AMCS recommended by the Board do not follow the statutory mandate, include assumptions that inflate savings, and should be rejected.

DATED: July 7, 2006

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